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SUPREME COURT, U.S.

No. 80-738

IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1980

IN RE: PENNHURST PARENTS-STAFF ASSOCIATION,
Petitioner and Movant

On Petition for Writ of Mandamus and Prohibition
to the United States District Court
for the Eastern District of Pennsylvania

RESPONSE OF TERRI LEE HALDERMAN, et al., TO PETITION FOR WRIT OF MANDAMUS AND PROHIBITION

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QUESTIONS PRESENTED

On June 30, 1980, the Court denied a six-pronged request for stays of various prior and future orders of the District Court in a case involving the statutory right of retarded people to be free of institutional abuse and to receive adequate programs in an appropriate setting. A stay was "granted to the extent that the judgment mandates the movement of residents of the Pennhurst facility to 'appropriate community living arrangements.' In all other respects, the motion is denied." On July 14, 1980, the District Court responded to the stay and ordered that "no resident of Pennhurst shall be transferred to a community living arrangement" unless it is determined that the transfer is voluntary. After hearing, in a July 29, 1980 Opinion, the District Court held that it had a duty to "ensure that residents and their families make informed judgments" and to ensure, as to voluntary transfers, "adequate provision for the safety and habilitation of the retarded residents."

1. Is mandamus an appropriate remedy to override the District Court's July 14, 1980 Order where a) the petitioner has no standing to seek mandamus, b) the petitioner waited four months since the order to seek mandamus, c) the District Court reasonably exercised its obligation to interpret this Court's Order, d) other remedies, including an appeal to the Court of Appeals and hearings before the District Court, are already in process on the issue sought to be raised, and e) the petitioner did not appeal or seek a stay of the District Court order?

2. Is alteration of the June 30, 1980 Order appropriate where petitioner waited four months to seek any relief, where alternative mechanisms to resolve particular disputes are in place and in use in the District Court, where further stay would amount to a decision on the merits, where the status quo is such that plaintiffs below would be irreparably harmed by any further stay and petitioner has failed to even allege irreparable harm?

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RESPONSE OF TERRI LEE HALDERMAN, et al.,
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Respondents Terri Lee Halderman, et al., respectfully urge the Court to deny the Petition for Mandamus and Prohibition, and for expansion of stay, filed by one of the petitioners in the cases soon to be argued, Nos. 79-1404, 79-1408, 79-1414, 79-1415 and 79-1489.[1]

The belated petition -- filed four months after the challenged order by a party which did not appeal or seek a stay of the order -- is submitted by a group with no standing to seek mandamus and with no grounds upon which the extraordinary writ may be granted. The question sought to be raised is at this time pending both in the Court of Appeals and in proceedings scheduled in the District Court. No grounds exist for modification of the existing stay.

STATEMENT OF THE CASE

I. The Court Orders

More than five months after the decision of the Court of Appeals for the Third Circuit under review here on the merits, Petitioner Pennhurst Parents-Staff Association filed a Motion for Stay in this Court requesting a stay of six separate categories of

1. Petitioner's application is typewritten and their request for leave to file a typewritten pleading is pending. Should their request be granted, respondents similarly request leave to file this response. Should petitioner's request be denied, respondents will file a printed response.

existing and future orders of the District Court:

> 1. A stay of paragraphs 1-11 of the order of March 17, 1978, as amended, in their entirety.
>
> 2. A stay of paragraphs 12-20 of that order insofar as those paragraphs require or depend upon the Special Master and other personnel and procedures established by that order.
>
> 3. A stay of the order of March 5, 1979, as amended, insofar as it requires or depends upon the Special Master and other personnel and procedures established by the district court's order.
>
> 4. A stay of the order of June 8, 1979, as amended, in its entirety.
>
> 5. A stay of Section V of the April 24, 1980 order in its entirety.
>
> 6. A stay of all future orders of the district court insofar as they relate to the transfer of people from Pennhurst and/or to the utilization of the Special Master, including but not limited to the district court's proposed order of May 20, 1980.

Had it been granted, the stay would have immobilized the district court and its master and would have condemned every one of the approximately 1000 people at Pennhurst, no matter what their desire and regardless of the actual availability of alternatives, to continued incarceration in an institution so bankrupt that its continued existence is not suggested by any party in this litigation.

Respondents opposed the stay motion on both legal and factual grounds including the following:

-- the irreparable harm to plaintiffs confined under conditions found "abominable" by every member of the Court of Appeals en banc;

-- the existence of a status quo under which planning for appropriate services had been ongoing for two years and three months;

-- the existence of procedures for individual class members to challenge any proposed placement outside the institution;

-- the failure of petitioner to seek the requested relief below;

-- the petitioner's delay in seeking a stay.

On June 30, 1980, the Court entered the following order denying every aspect of the six requested stays but one:

> Petitioner's motion for a stay of the judgment of the Court of Appeals, pending final disposition of the cases in this Court, is granted to the extent that the judgment mandates the movement of residents of the Pennhurst facility to "appropriate community living arrangements." In all other respects, the motion is denied.

Responding to this Order, the District Court on July 14, 1980 ordered that "no resident of Pennhurst shall be transferred to a community living arrangement in accordance with prior Orders of this Court unless and until the Hearing Master has determined that such transfer is necessary." The court also set a hearing for July 21, 1980 to receive memoranda and argument form the parties on any further orders that might be required in light of the Supreme Court's order of June 30.

On July 29, 1980, the District Court filed a five page opinion finding:

> There is absolutely no support for the Parents-Staff Association's position that the Supreme Court intended to close the doors of Pennhurst, forbidding anyone to leave. As to the position of the Commonwealth and Counties that voluntary transfers may proceed, but that this Court has no authority in connection with such transfers, we must look to the motion for stay and the precise wording of the Supreme Court's Order. The motions sought a stay of paragraphs 1 through 11 of the Order of March 24, 1978 [correct date: March 17, 1978], as amended, which set forth specific procedures for planning, development and monitoring of community living arrangements. A stay of the Order of June 8, 1979, which provided specific steps for transferring the school-age residents of Pennhurst to the community, was also sought. Further, the Parents-Staff Association sought to stay Part V of the Order of April 24, 1980, which provided for individual determinations as to the appropriate habilitation for Pennhurst residents, as mandated by the Court of Appeals for the Third Circuit. If the Supreme Court had intended to terminate the involvement of this Court in the voluntary movement of Pennhurst residents to the community, it could easily have done so by specifically granting the three

stay requests.

Slip Opinion of July 29, 1980 at 3-4. Judge Broderick understood the June 30 Order to mean what it said:

> We understand the word "mandate" to have its literal meaning -- that this Court cannot mandate the movement of residents from Pennhurst to the community. Nothing in the Supreme Court stay order suggests, however, that voluntary transfers may not proceed, nor that this Court may not ensure that residents and their families make informed judgments as to such voluntary placements.

Id. at 4(emphasis supplied). Finally, the District Court recognized its duty to approve movement of class members once their safety and care were ensured:

> Furthermore, we find nothing in the Supreme Court stay order to prevent this Court, with the assistance of its Special Master and Hearing Master, from ensuring that such voluntary transfers make adequate provision for the safety and habilitation of the retarded residents.

Id. at 4-5.

There is a context to these actions of the District Court not mentioned in the mandamus petition. On July 15, 1980, the court received a report from experts retained by the Special Master (and selected with the concurrence of the Commonwealth) as a result of a contempt motion filed by plaintiffs Halderman, et al., regarding the deaths of 50 Pennhurst residents since the March 17, 1978 Order. That report, finding that residents were dying preventable deaths and that medical care at Pennhurst is shockingly inadequate, prompted the District Court to order the Commonwealth defendants to show cause why they should not be held in contempt of court. The report on deaths is attached hereto as Exhibit A and the July 22, 1980 Order to Show Cause is attached as Exhibit B.[2]

II. The State and County-operated process for community placement is unhindered; successful movement is occurring.

No person has left Pennhurst or is leaving Pennhurst without the approval and support of the Commonwealth and County for

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2. At the August 4, 1980 hearing on contempt, the Commonwealth agreed to adopt the report's recommendations and the hearing was recessed to permit the parties to attempt to negotiate remedies. The negotiations broke down and the matter is again before the Court.

a particular proposed placement. These defendants themselves, not the Court or its master, must formulate a habilitation plan and provide services. Order of March 17, 1978. para. 1 and 2.

For every Pennhurst resident whose placement the Hearing Master has reviewed, the Commonwealth approves the proposed site and ensures staff training. Order of June 8, 1979, para. 11. The County provides those services it has itself planned for. Id. at para. 7 and 14.

No current resident in the placement process can move to an individualized program unless the Commonwealth provides a formal assurance statement:

> Assurance statement says that the proposed CLA and other community services will be more beneficial to the resident than the services and living arrangements at Pennhurst Center.

Guidelines for Case Managers 9 n. 1 (Office of the Special Master, August, 1980).

There is no obstacle to the state and county defendants continuing the community placement process they claim to support. The court below, as the Court here, has carefully limited its role to oversight of the process, a process which has resulted in great benefit to Pennhurst residents. Since March 17, 1978:

1. 85.9% of people leaving Pennhurst are in community programs. Table I Report to the Court: The Individuals Who Moved From Pennhurst 3 (Office of the Special Master, October 1, 1980)("Report"). The table is attached as Exhibit C; the full report has been lodged with the Clerk of the Court.

2. Most people who have been relocated to the community have no difficulty in hearing (86.9%), seeing (72.1%) or walking (68.9%). Tables VII and VIII, Report, attached as Exhibits D and E.

3. Vists by family to former Pennhurst residents have increased 300% since their move; trips with family members have increased 1,200%. Table X, Report, attached

as Exhibit F.

4. Participation of family in program planning for community care is present for 61.5% of residents (an additional 13% have no family). While at Pennhurst, family's participation for these residents was at the 12.3% level. Table XI, Report, attached as Exhibit G.

5. Programs and medical care previously unavailable at Pennhurst are now being provided to plaintiffs whose improvement in many cases has been dramatic. Report at 24-33.

As the attached affidavits show, Exhibits H through N , no "bureaucracy" exists to interfere with informal and successful placement efforts and, of greater importance, parents and residents alike anxiously await the day when they will be freed of concern with the lack of care at Pennhurst. For example,

Petitioner's objections to the Hearing Master process (which the Court was asked to stay in June but for which a stay was denied) appear to center on one particular hearing, that for G.W., No. 80-P-16, as to whom a motion for stay and exceptions are pending in the District Court, which is scheduling a hearing for the near future. The silence of petitioner regarding the other hearings is understandable because the actual process, summarized in the Chart on the next page, demonstrates that:

1. Of the 21 hearings on movement from Pennhurst, 19 have involved parental approval of a proposed placement.

2. Of the 21 hearings, all 21 involved County and Commonwealth approval of the proposed placement at or before the hearing.

3. Of those hearings, in many cases -- 6 in all -- it was found that what was proposed by the state and county was not adequate to meet the needs of the resident or the concerns of parents and adjustments were necessary.

4. In the two cases where parents did not approve of the placement (one involving an adult, G.W., and the other a minor, P.T.), the parents and the counties filed exceptions and those exceptions are to be heard by the District Court.

There has thus been no order of the District Court mandating the movement of any resident from Pennhurst. The only movement has been voluntary.

Nor has every case even required an informal hearing. In several cases, noted in the Chart, parents have expressed their approval of a placement by telephone and, no party objecting, the voluntary placement has gone forward. In every case but those in which exceptions are pending, there has been no dispute and no attorneys.[3]

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3. For G.C. who is George Sorotos Caranfa, an original plaintiff, his attorney David Ferleger appeared to witness the confirmation of what Mr. Caranfa and his family sought when suit was filed in 1974. See affidavit attached as Exhibit L . In two other cases, the county, but no other party, had an attorney.

SUMMARY OF PROCEEDINGS OF HEARING MASTER

REGARDING COMMUNITY PLACEMENTS OF PENNHURST RESIDENTS

Number	Client Initials	Age of Client*	Parent Approval of Transfer	Hearing Date**	Services in Place	Parties Represented by Attorneys	Hearing Master's Action	Exceptions to program filed
80-P-1	C.K.	20	yes	8/15 (phone)	yes	none	approved	no
80-P-2	G.C.	17	yes	8/15	yes	parents	approved	no
80-P-3	P.V.P.	20	yes	8/13 (phone)	yes	none	approved	no
80-P-4	P.T.	18	no	9/16, 10/1	partial	parents, P.T., County, Commonwealth	disapproved	yes
80-P-5	M.R.	15	yes[1]	9/9	yes	none	approved	no
80-P-6	E.M.	21	yes[1]	8/25	partial	none	conditional approval	no
80-P-7	W.M.	21	yes[1]	8/25	partial	none	conditional approval	no
80-P-8	L.B.	21	yes	8/25	partial	none	conditional approval	no
80-P-9	R.S.	17	yes	8/26	yes	none	approval	no
80-P-10	S.P.	18	yes	9/2, 10/9	yes	none	conditional approval	no
80-P-11	N.T.	21	yes	9/3	partial	none	approval	no
80-P-12	S.M.R.	-- dismissed prior to hearing, --						
80-P-13	R.A.P.	21	yes	9/3, 10/15	yes	none	approval	no
80-P-14	M.Z.	18	yes	9/9	yes	none	approval	no

80-P-15	J.H.	19	yes	9/5	yes	none	approved	no
80-P-16	G.W.	19	no[2]	9/29, 9/30, 10/7	yes	parents, G.W., Commonwealth	approved	yes
80-P-17	J.S.	22	yes (sister)	10/14	partial	County	deferred decision -- pre-placement visit	no
80-P-18	W.P.	22	yes	10/15	yes	none	approved	no
80-P-19	R.G.	22	yes (sister)	10/24	yes	none	approved	no
80-P-20	D.O.	21	yes	10/31	yes	none	approved	no
80-P-21	-- Report of Hearing Master not yet filed --							
80-P-22	M.J.	20	yes[3] (certified advocate)	10/31	yes	County	approved	no

* Although by far most of the residents of Pennhurst are adults, pursuant to the District Court's Order of June 8, 1979, these hearings have involved the movement of school-age children to community placements.

** Hearings were held in all cases, except for those indicated by (phone). In these instances, the parent called to express approval of the plans for transfer, and as there were no unresolved issues regarding the move, to which all parties consented, there was no hearing.

Additional notes on page 7-C

1. In addition, the Certified Advocate appointed for the client approved the transfer.
2. In this instance, the parents opposed the transfer but the Certified Advocate was in favor of the placement.
3. This client has no parents, but her appointed Certified Advocate favored the placement.

SUMMARY OF ARGUMENT

Mandamus Should Be Denied

1. "The remedy of mandamus is a drastic one, to be invoked only in extraordinary circumstances." Kerr v. United States District Court, 426 U.S. 394 L976). A lower court must have usurped power and acted outside of its jurisdiction, or refused to perform a duty, for the writ to issue. Here, the District Court exercised its conceded jurisdiction with wisdom and restraint.

2. Petitioner has no standing to seek mandamus. This group of institutional employees and parents who oppose the relief granted below has standing to assert only claims by parents who object to "forced" movement of minor children. It has no standing to object to the movement of others who wish to leave the abominable conditions at Pennhurst or those who desire the protection of the District Court for their services outside the institution. In the only actual case of objection presented in the petition, that of G.W., a hearing is scheduled in the District Court to hear the same objection submitted here. In addition, having failed to appeal the disputed July 14, 1980 order, the petitioner has no standing now to seek mandamus. In re Humes, 149 U.S. 192, 194 (1893); Re Rice, 155 U.S. 396 (1894).

3. Confronted with this Court's near total denial of petitioner's six-pronged attempt to stay virtually every portion of the District Court's prior and future orders, the District Court had a duty to interpret the meaning of this Court's June 30, 1980 Order. From 1795 until today, this Court has held that discretion which vests in a lower court to make judgments and interpret the law is never a fit subject for mandamus. United States v. Lawrence, 3 U.S. 42, 53 (1795); Will v. Calvert Fire Ins. Co., 437 U.S. 655, 665 (1978). If this Court intended Judge Broderick to exercise his judgment upon receipt of its stay order, mandamus cannot be used to override that exercise.

4. Mandamus is not appropriate because other remedies, including appeal, are presently in process. The very question presented

in the mandamus petition is pending below in both the Court of Appeals (3d Cir., No. 80-2341) and in the District Court (in a motion for stay and exceptions to two placement reports). Where another remedy is available, mandamus may not be invoked. Helstoski v. Meanor, 442 U.S. 500 (1979). Mandamus is not a substitute for appeal, even if hardship and delay result. Will v. Calvert Fire Ins. Co., 437 U.S. 655 (1978); Ex parte Fahey, 332 U.S. 258 (1943); Kerr v. United States District Court, 426 U.S. 394 (1976).

5. An interlocutory order of a trial court is not subject to review on mandamus except in the rare case of a pattern of repeated and flagrant violation of clear rules of law. E.g., Will v. United States, 389 U.S. 90 (1967); LaBuy v. Howes Leather Co., 352 U.S. 249 (1957), or in similarly unusual cases such as Ex parte Peru, 318 U.S. 578 (1943), touching on delicate foreign relations matters. The strongest argument petitioner could make in this Court is that, with certiorari granted, the Court must make a special effort to supervise interlocutory orders below which might be made unnecessary by the Court's ultimate ruling on the merits. The identical contention has been rejected by the Court in Ex parte Wagner, 249 U.S. 465 (1919). Just as other interlocutory orders in district courts are held insulated from mandamus review, so too the order below and the reports of the Hearing Master should be reviewed only in the normal course.

6. Assuming that the District Court was wrong in its interpretation of the Court's stay order, that error is not subject to correction on mandamus. Will v. Calvert Fire Ins. Co., 437 U.S. 655 (1978); Ex parte Burtis, 103 U.S. 238 (1881).

7. The four month delay between the challenged order of July 14, 1980 and the filing of the mandamus petition, of itself, is ground for denial of the extraordinary writ. Re Eastern Cherokees, 220 U.S. 83 (1911); Re Hohorst, 150 U.S. 653 (1893).

Alteration of the Stay

8. Petitioner's alternative prayer for an expansion of the existing stay should be denied. There is no basis for granting now what was denied five months ago.

9. The long and unexplained delay "vitiates much of the force of their allegations of irreparable harm." Beame v. Friends of the Earth, 434 U.S. 1310, 1313.

10. Petitioners did not appeal the challenged order and sought no stay from the District Court or the Court of Appeals.

11. Where an alternative mechanism to resolve disputes exists, where 1000 people at Pennhurst would suffer to avoid speculative injury to an unidentified handful, and where a blanket stay would be tantamount to a decision on the merits, a stay should be denied.

12. The status quo -- carefully planned provsion of state and county-designed services in the community and protection from abuse of people in the institution -- has been in uninterrupted operation for two and one half years. The Court declined to interrupt that status quo in June of this year. Only denial of a further stay will preserve the status quo. Houchins v. KQED, 429 U.S. 1346 (1976).

13. Plaintiffs below would be irreparably harmed by a stay. The findings of the District Court on the harms of Pennhurst are uncontradicted and unchallenged. People whose placements are in process, who are in pre-placement visits and who desire and need to leave Pennhurst, would be left in the lurch by the precipitous and dangerous stay requested.

14. Petitioner alleges no harm to itself to justify any further stay than the one obtained in June, 1980. The state and counties, implementing their own policies of deinstitutionalization, suffer no harm.

ARGUMENT

I. Mandamus, especially as the behest of a petitioner with no standing, is inappropriate where no extraordinary circumstance exists, where petitioner delayed four months in seeking relief in this Court and sought no relief below, and where other adequate remedies, including appeal, are in process.

A. There being no "clear and indisputable" right and no "judicial usurpation of power," mandamus may not be invoked.

"The remedy of mandamus is a drastic one, to be invoked only in extraordinary circumstances." Kerr v. United States District Court, 426 U.S. 394, 402 (1976), where there is a "judicial 'usurpation of power,'" id., quoting Will v. United States, 389 U.S. 90, 95 (1967). The right must be "clear and indisputable." Will v. Calvert Fire Ins. Co., 437 U.S. 655, 662 (1978). Mandamus is used to confine an inferior court to a lawful exercise of its prescribed jurisdiction or to compel it to exercise its authority when it is its duty to do so." Will, supra, 437 U.S. at 662.

Despite the strenuous attempt of the petitioner group, which includes employees at the institution, to mold the facts to their liking, there is no extra-jurisdictional action of the court below and no failure to exercise a duty. There is no clear and indisputable right to the relief sought because the cautious District Judge[4] exercised his authority in a legitimate and restrained fashion.

Although, in justice, the inquiry should stop here, an examination of the other considerations in mandamus, conducted in the folowing pages, further supports prompt and summary denial of the petition.

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4. Hon. Raymond J. Broderick, whose dissenting opinion was cited with approval by the Court in Secretary v. Institutionalized Juveniles, 442 U.S. 640, 645 n. 7 (1979), was similarly careful here to balance competing interests in accordance with this Court's action. Petitioner's attempt to confuse the "voluntariness" of placement with the "involuntariness" of confinement to Pennhurst in the absence of alternatives defies logic or sense and was not accepted by the Court below.

B. Petitioner has no standing.

There is no standing in the petitioner to seek mandamus.

Petitioner for mandamus is an organization of employees of Pennhurst and some parents who oppose the relief granted below. The group here asks the Court to prohibit even voluntary movement from being approved by the court below, even for minors with parents who vigorously support the movement, despite that court's conceded jurisdiction over the parties and duty to protect respondents from injury and abuse.

The petitioner has standing to assert only claims by parents who object to "forced" movement of minor children. Petitioner has no standing to interfere with movement of minor residents with parental support or adult residents who wish to leave.

In the only actual case of objection presented in the petition, G.W., there are pending in the District Court exceptions and a motion for stay. A hearing is scheduled for the near future and, of course, nobody knows what the result will be. Petitioner certainly cannot bring that hypothetical case here at this time.

In addition, having failed to appeal the disputed July 14, 1980 Order, petitioner cannot now circumvent that failure thorugh mandamus. See Section D below.

There is no standing in petitioner to obtain the relief sought. See In re Humes, 149 U.S. 192, 194 (1893)(mandamus denied; petitioners not parties to the writ of error and "not so concerned in the execution of the mandate as to be entitled" to mandamus review); Re Rice, 155 U.S. 396, 403 (1894)("where the application is made by a stranger").

C. Mandamus cannot issue to override the District Court's exercise of reasonable judgment in implementing this Court's June 30, 1980 Order.

Confronted with this Court's near total denial of petitioner's six-pronged attempt to stay virtually every portion of its prior and future orders, the District Court had a duty to interpret the language granting a narrow partial stay "to the extent that the judgment mandates the movement" of people from Pennhurst.

This duty to interpret involves of necessity an exercise of judgment and discretion and requires review of existing orders, motions, the parties' positions and the burdens to be borne by the participants in the litigation and the public interest. This Court having wisely chosen not to dictate the manner in which its stay action was to be effected, the District Court initiated proceedings and entered a limited order.

Since at least 1795, this Court has held that it has "no power to compel a Judge to decide according to the dictates of any judgment, but his own." United States v. Lawrence, 3 U.S. 42, 53 (1795)(denial of request by U.S. Attorney General for mandamus to District Judge). This principle has not been eroded since; discretion which vests in lower courts is never a fit subject for mandamus:

> Although the District Court's discretion may be subject to review and modification in a proper interlocutory appeal, [citation omitted] we are convinced that it ought not to be overridden by a writ of mandamus.

Will v. Calvert Fire Ins. Co., 437 U.S. 655, 665 (1978)(note omitted).[5]

Only where a ministerial duty leaves no room for any discretion is mandamus appropriate; thus, mandamus is approved where

> There is no room for the exercise of any discretion, official or otherwise: all that is shut out by the direct and positive command of the law, and the

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5. Accord, Ex parte Hoyt, 38 U.S. 279 (1839); United States ex rel. Goodrich v. Guthrie, 58 U.S. 284 (1855); Ex parte Brown, 116 U.S. 401 (1886)("This rule is elementary"); Roche v. Evaporated Milk Ass'n, 319 U.S. 21 (1943).

> act required to be done is, in every just sense, a mere ministerial act.

Kendall v. United States, 37 U.S. 524, 614 (1838).[6]

If this Court intended Judge Broderick to exercise his judgment upon receipt of the June 30, 1980 Order, mandamus cannot be used to override that exercise.

D. Other remedies, including appeal, are in process, thereby rendering mandamus inappropriate.

The very question presented in the mandamus petition is pending below in both the District Court and the Court of Appeals:

1. Before the District Court are exceptions to the Hearing Master's Reports in Nos. 80-P-4(refusing to approve placement) and 80-P-16 (approving placement). Both raise the question of interpretation of the stay. A hearing in 80-P-16 is set for the near future.

2. Before the District Court is a Motion for Stay regarding the adult Pennhurst resident G.W. whose parents (affiants on the mandamus petition) seek to use this Court's stay to prolong his confinement at Pennhurst for reasons the Hearing Master carefully scrutinized (see opinion of Hearing Master, attached to mandamus petition), the County and the Commonwealth explicitly testified to their support of his placement in the home which awaits him. The stay motion pending in the District Court addresses the mandamus issue.

3 Before the Court of Appeals is the Commonwealth's appeal from the July 14, 1980 Order at issue in this mandamus petition (3d Cir., No. 80-2341.

Where another remedy is available, mandamus may not be invoked; only in the absence of any other means of asserting a claim can the extraordinary writ be employed. Chief Justice Burger,

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6. Even the payment of a judge's salary has been held a non-ministerial act insulated from enforcement by mandamus. United States ex rel. Goodrich, supra note 5.

quoting and adding emphasis to an earlier opinion, recently expressed this principle for the Court:

> The general principle which governs proceedings by mandamus is, that whatever can be done without the employment of that extraordinary writ, may not be done with it. It lies only when there is practically no other remedy.

Helstoski v. Meanor, 442 U.S. 500, 505 (1979), quoting, Ex parte Rowland, 104 U.S. 604, 617 (1882).[7]

An appeal and other reviews are pending in the case at bar, not merely available. Mandamus is no substitute for appeal, Will v. Calvert Fire Ins. Co., 437 U.S. 655 (1978), even if hardship and delay result. Bankers Life and Cas. Co. v. Holland, 346 U.S. 379 (1953); Ex parte Fahey, 332 U.S. 258 (1947); Roche v. Evaporated Milk Ass'n, 319 U.S. 21, 27-28 (1943); Re Rice, 155 U.S. 396, 403 (1894)(mandamus unavailable even if no appeal is permitted by law); Re Humes, 149 U.S. 192 (1893); U.S. Alkali Export Ass'n, Inc. v. United States, 325 U.S. 196, 202-203 (1945).

Where the Court was asked to order a district judge to vacate an order, mandamus was denied with this explanation of the writ's relation to appeals:

> Mandamus, prohibition and injunction against judges are drastic and extraordinary remedies. We do not doubt power in a proper case to issue such writs. But they have the unfortunate consequence of making the judge a litigant, obliged to obtain personal counsel or leave his defense to one of the litigants before him. These remedies should be resorted to only where appeal is a clearly inadequate remedy. We are unwilling to utilize them as substitutes for appeals. As extraordinary remedies, they are reserved for really extraordinary causes.

Ex parte Fahey, 332 U.S. 258, 260 (1947). Here, where the petitioner has failed to exhaust pending review opportunities (this petitioner has even failed to appeal), failed to seek stays or mandamus relief from the courts below, failed to seek a rehearing below, and waited four months to file this mandamus petition, there is obviously no basis for finding mandamus the only available remedy.

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7. Accord, Kerr v. United States District Court, 426 U.S. 394, 403 (1976)("no other adequate means to attain the relief"); Re Rice, 155 U.S. 396, 403 (1894).

Where "an alternative, less extreme, path to modification of the challenged" order is available, mandamus is denied. Kerr v. United States District Court, 426 U.S. 394, 396-397 (1976).

E. Mandamus is inappropriate to disturb an interlocutory order which does not affect the merits.

After review on the merits on appeal and a final judgment in this Court, mandamus is proper to ensure that the decree is given full effect below. [8] However, an interlocutory order of a trial court is not subject to mandamus except in the rare case of a pattern of repeated and flagrant violations of clear rules.[9] E.g., Will v. United States, 389 U.S. 90, 104, 105 (1967)(no showing of "deliberate disregard" of criminal discovery rules; mandamus denied); LaBuy v. Howes Leather Co., 352 U.S. 249, 258 (1957)(repeated improper actions by district court; mandamus granted); Ex parte Burtis, 103 U.S. 238 (1881)(mandamus denied to compel subpoena obedience); Re Hawkins, 147 U.S. 486 (1893) (mandamus denied to compel receipt of evidence).

The strongest argument petitioner could make in this regard is that, with certiorari granted in the case, this Court has a special duty to supervise implementation below on interlocutory matters. In the only case on point discovered by counsel, this Court rejected the identical contention. In Ex parte Wagner, 249 U.S. 465 (1919), two related cases had been heard in the Sixth and Second Circuits; after certiorari had been granted in one case, the question arose whether the trial court could require an accounting (which might prove valueless, depending upon the Court's decision on the merits) pending the Supreme Court's plenary review. The Court denied mandamus:

> Mandamus is an extraordinary remedy, to be resorted to for the purpose of securing judicial action, not for determining in advance what that action shall

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8. Vendo Co. v. Lektro-Vend Corp., 434 U.S. 424, 427 (1978); General Atomic Co. v. Felter, 436 U.S. 493 (1978); In re Sanford Fork and Tool Company, 160 U.S. 247 (1895). Cf., Ex parte Whitney, 38 U.S. 404 (1839)(clear but single disregard of rules; mandamus denied).

9. One other exception has been a case touching on delicate foreign policy questions. Ex parte Peru, 318 U.S. 578 (1943).

> be. In re Rice, 155 U.S. 396. It may not be resorted to, as the petitioners seek to resort to it here, for the purpose of controlling minor orders made in the conduct of judicial proceedings, and the fact that the result of litigation may possibly be such that interlocutory proceedings taken may not prove of value is not a sufficient reason for calling the writ into use for the purpose of forbidding such proceedings, even though the cost of them cannot be recovered from the opposing party or even though the order cannot be reversed on error or appeal.

Id., 249 U.S. at 471. See also, Kerr v. United States District Court, 426 U.S. 394 (1976)(mandamus denied re discovery orders in class suit).

The handful of reports filed by the Hearing Master, and the absence of any order of Judge Broderick compelling any movement from Pennhurst, and the fact that this Court previously denied a stay of the individual determination process, all suggest that the July 14 interlocutory order is not a fit subject for mandamus review.

F. If the order below was wrong, mandamus is not a proper mode for its correction.

Inapplicability of mandamus to correct errors below, including reversible errors, is a consequence of its inapplicability to discretionary acts. Assuming that the District Court was plain wrong in its interpretation, it may not be made a litigant before this Court and have its error corrected on mandamus. Will v. Calvert Fire Ins. Co., 437 U.S. 655 (1978).

Mandamus "does not apply at all to a judicial act to correct an error, as where the act has been erroneously performed." Ex parte Newman, 81 U.S. 152, 169 (1872). Accord, Ex parte Hoyt, 38 U.S. 279 (1839); De Beers Consolidated Mines, Ltd. v. United States, 325 U.S. 212, 217 (1945). The concept was well expressed by Chief Justice Waite:

> The district judge took jurisdiction of the matter, as it was his duty to do, heard the parties, and decided adversely to the claim of the petitioner. In this he may have done wrong, and the reasons he has assigned may not be such as will bear the test of judicial criticism; but we cannot, by mandamus, compel him to undo what he has done in the exercise

of his legitimate jurisdiction.

Ex parte Burtis, 103 U.S. 238 (1881).

The error, if one there be, will be corrected by the Court of Appeals in the pending appeal, or through this Court's review on the merits. Mandamus does not lie in these circumstances.

G. The four month delay in filing the petition justifies its denial.

Having sought a stay in this Court in June, 1980, and having forcefully litigated its meaning in the District Court in July, 1980, the Petitioner sat on its heels for four months without uttering a word in this Court regarding what it now claims to be disregard of this Court's Order. It can certainly be no coincidence that this mandamus petition is filed on the eve of oral argument

Such delay in seeking mandamus is, of itself, grounds for denial of the extraordinary writ. Re Eastern Cherokees, 220 U.S. 83 (1911); Re Hohorst, 150 U.S. 653 (1893). See, Lucas v. United States ex rel. Heineman Chemical Co., 36 F.2d 1015 (1929); United States v. Carter, 270 F.2d 521 (9th Cir. 1959).

II. Alteration of the June 30, 1980 Order is not appropriate.

Petitioner's alternative prayer is for an expansion of the narrow stay of June 30, 1980. There is no basis for granting now what was denied five months ago.

A. Petitioner's long and unexplained delay since July 14, 1980 in filing this request "vitiates much of the force of their allegations of irreparable harm." Beame v. Friends of the Earth, 434 U.S. 1310, 1313 (Marshall, J., as Circuit Justice).

B. Petitioner did not appeal from the challenged order and has not sought a stay from the District Court or the Court of Appeals.

C. Where an alternative mechanism for dispute resolution and assessment of injury is in place, as here, a blanket stay is unnecessary. Cousins v. Wigoda, 409 U.S. 1201, 1205 (1972)(Rehnquist, J., as Circuit Justice); O'Brien v. Brown, 409 U.S. 1 (1972)(per curiam).

D. A stay of an order granting relief to 1000 people at Pennhurst should not be granted to avoid speculative injury to a handful. See Wasmuth v. Allen, 85 S.Ct. 5, 6 (1964)(Harlan, J., as Circuit Justice)(school testing).

E. The blanket stay requested would be tantamount to a decision on the merits and should not be granted without full hearing. National Socialist Party of America v. Village of Skokie, 434 U.S. 1327 (1977)(Stevens, J., as Circuit Justice); Cousins v. Wigoda, 409 U.S. 1201, 1205 (1972)(Rehnquist, J., as Circuit Justice).

F. The status quo -- carefully planned provision of state and county-designed services -- has been in uninterrupted operation for two and a half years. The people receiving services require the protection of the lower court's orders. See affidavits H through N, attached hereto. The Court declined to interrupt that status quo in June of this year. Only denial of a further

stay will preserve the status quo. Dayton Board of Education v. Brinkman, 99 S.Ct. 27 (1978)(Stewart, J., as Circuit Justice); Houchins v. KQED, 429 U.S. 1346 (1976)(Rehnquist, J., as Circuit Justice). A stay would throw a complex and delicate system into chaos.

G. Plaintiffs below would be irreparably harmed by a stay. The findings of the District Court on the harms of Pennhurst are uncontradicted and unchallenged. Adult Pennhurst residents who desire to leave Pennhurst would be unnecessarily confined under an illegal regime. People whose placements are in process and for whom services are now available would be denied the Hearing Master's review to ensure safety, voluntariness and habilitation. People now free of Pennhurst and appropriately placed would be without the protection of court orders on which they have relied. See attached affidavits, including the affidavit of Abraham Zlotnikoff, now 76 years old who spent 70 years at Pennhurst and who now works, is cooking, bowling and doing his own laundry, all in a community living arrangement developed as a result of the lower court's orders. Not only are there people now at Pennhurst who are preparing to leave but there are people now living in a community facility on a pre-placement visit, but still on Pennhurst rolls, whose fate will be a return to Pennhurst if this Court expands the stay.

H. Petitioner will not be harmed by the maintenance of the stay now in effect. The Association alleges no harm to itself or its members. The Commonwealth and the Counties, approving every placement, suffer no harm except the necessity to occasionally modify a proposal. Apart from implementing their own notions of community placement, the Commonwealth simply seeks to be left alone to do as it sees sit, as if there had never been a trial, findings of liability, and the repeated refusal of the defendants to come up with a plan of their own to remedy the harms to plaintiffs.

CONCLUSION

For the above reasons, the petition for mandamus and prohibition and the request for expansion of stay should be denied. This belated request, timed to obfuscate the issues to be presented shortly in oral argument, has no merit.

Respectfully submitted,

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Report of Visit
Pennhurst Center
Spring City, Pennsylvania
June 28-29, 1980

I. Introduction

At the request of the Office of the Special Master, Federal District Court, Pennhurst Center was visited by James D. Clements, M.D., and John W. Gallagher, M.D., on June 28-29, 1980, for purposes of gaining an overview of medical and related services, with particular emphasis upon the institution's recent mortality experience.

The practice of medicine is both an art and a science. In a closed institutional environment it is imperfect at best due to the kaleidoscopic influences, both physical and mental, affecting clients' well-being. Observations of behavior or lack of behavior, so important in determining peoples' states of health, are difficult to collect consistently due to the multiple authority figures who in effect govern the lives of institutionalized retarded people -- a multiplicity brought on by staff turnover, reassignments, shift changes, overcrowding, etc. Even when data collection is consistent, its interpretation may be confounded by this fragmentation of authority figures or by failure to consider physical (often neutrally-perceived) discomfort as a cause of severe maladaptive behavior in these unable to verbalize their pain. It is therefore mandatory that the large, variable, and sometimes discordant group of individuals, both direct-care and professional, who govern the lives and efforts on behalf of the people they control: precise observations succinctly recorded, carefully individualized [illegible] treatment techniques must be drawn together into [illegible] practice. This principle surely applies most truly to institutional medical practice: because of physicians' unique authority bestowed by law and custom

A1 Exhibit A

to order that institutionalized persons be treated in some particular way, they have the highest possible moral and legal duty to practice according to this standard. At Pennhurst, we find that for a wide variety of reasons this duty is often not fulfilled.

II. Observations

Due to the limited time available for this visit, observations were necessarily selective rather than comprehensive. Prior to our visits we examined in detail portions of records supplied to us for over forty Pennhurst clients who had expired during the period March 1978 through June 1980: this review included death summaries prepared by physicians, and where available, autopsy reports. Some of these were designated for more detailed record review during our visit. In addition, in order to obtain a retrospective on current patterns of care records of several living clients were also examined on site, and observations made of these clients' living environment and general condition. Comments about a number of these clients will be offered below.

Records of deceased and living clients shared certain characteristics. We found gaps, sometimes of several months, in documents' dates; these gaps were often just prior to the terminal event. Progress notes were fragmented and multidisciplinary, creating misunderstandings: for example, one "discipline" staff member would note that the resident appeared ill while on the same day, on the same record, another would note that the resident was doing well. In many instances, in the records of deceased residents, it became obvious that signs of problems were present long enough before the

terminal event, that if heeded and acted upon could prevent death or mitigate the threat of serious accident or disease.

Item: resident J S , who died in January 1979 after strangling on a sock, was known to have passed a sock in his stool several days earlier; late the previous month he was known to have ingested yet another sock, and the next day a "non-nutritive substance". The medical response to these previous episodes consisted of an order that he wear "muffs" (presumably some kind of restraint mitten): no evidence could be found that the use of the muffs was monitored, nor that the behavior in question had abated; neither was there any evidence of attempts to eliminate the behavior through appropriate training.

Item: M N expired in May 1978 from complications of congenital heart disease. The record shows that cardiology consultation to evaluate the possibility of corrective surgery was recommended by an orthopedic consultant in October 1974; another consultant again suggested this in July 1975. Examination of the record shows no evidence that even the possibility of cardiac consultation was ever seriously entertained for this purpose by Pennhurst staff, let alone the possibility of corrective heart surgery.

Item: D B , whose death in March 1978 was attributed to status epilepticus (autopsy report) was taking four different anticonvulsant drugs: despite persistence of seizures over eight about once per month, no reports of nor orders for anticonvulsant drug blood levels could be found in his record.

Item: M B , whose death in October 1978 was attributed to seizures, had had a series of severe seizures on May 18, 1978, at which time he was taking Dilantin and phenobarbital. The attending physician increased the dose of Dilantin the next day, but blood levels of phenobarbital and Dilantin performed three weeks later showed that both drugs were still being given in sub-therapeutic amounts. Despite this evidence of inadequate therapy, during the remaining 4 1/2 months of the resident's life the physician neither changed the dose of these drugs nor documented any reason for not doing so.

The cases cited above typify the standard of medical care shown in the records which we reviewed. Problems of this kind could surely be ameliorated by better coordination and standardization of medical and medically-related care at Pennhurst, together with more consistent efforts by all staff members to identify and respond in a more sensitive and individualized manner to each resident's needs.

In literally all the records reviewed, of Pennhurst residents both living and deceased, it can be stated that documentation of the process of medical diagnosis and treatment is scandalously poor. Though it is often possible to trace (and with the use of informed imagination, to justify) the management of acute ailments (pneumonia, etc.), it is just as often not possible to do so with chronic ones. Multihandicapped patients regularly receive long lists of medications of various kinds while having no stated diagnoses, signs, or symptoms which would explain the drugs' use. In Capitol Hall I, for example (which we visited because of its rather high incidence of resident deaths), we commonly found residents receiving from six to twelve or more medications,

of which many have serious known adverse side effects, with literally no identifiable justification for using them. Why, for example, does F F receive Thorazine and Valium? Valium, it might be speculated, relieves her spasticity; but nowhere is there an observation as to whether her spasticity is in fact improved by it: instead, one finds Valium reordered, month after month, in a shopping list of medications written by (presumably) a nurse and signed, by rote, by a physician. Does Ms. F show or not show tardive dyskinesia, a known side effect of Thorazine? We cannot tell from the record; all we know is that Ms. F receives Thorazine for an unidentified reason. Why has she for at least the past fifteen months received Tagamet, a drug indicated for short-term (a few weeks to a few months) treatment of upper gastrointestinal ulcers or bleeding? The record is silent on this. While we ourselves might in rare cases use Tagamet for longer periods than indicated by its present FDA-approved labelling, we would insist on proper documentation of the reasons for doing so, and the result thereof. Such documentation is absent from Ms. F 's record. And why does she receive Diazide, a diuretic capable of further compromising her already borderline hydration status, when there is no documented indication for it in her record?

While in Capitol Hill I we reviewed the [illegible] of A R , who has multiple motor handicaps in addition to a seizure problem for which she receives Dilantin. In recent months Ms. R has been in a poor state of health: she was admitted to a Pennhurst infirmary unit several weeks ago, and while there the concentration of Dilantin in her bloodstream was found to be excessively high. This problem was treated with good results in the infirmary, according to the record, and she was transferred back to Capitol Hill I: since then, according to the record and to staff members whom we interviewed, her condition

has again seemed to deteriorate, with progressive difficulty in maintaining adequate oral intake of food and fluids. It is our experience that inadequate food and fluid intake can result in concentration of drugs such as Dilantin to toxic levels, but no Dilantin blood level test has been done on Ms. K since the beginning of her latest deterioration. To us this suggests at the least inattention to a known risk factor. If such is not the case, it is not documented in her record.

The effects of poor documentation of the medical diagnosis/treatment paradigm are extensive. Pennhurst currently utilizes an "after hours" (night and weekend) medical coverage system which places a premium upon the ability of part-time physicians to assess and treat acute problems in residents whose long-term medical conditions, and the rationale for medications being used to treat those conditions, is at best occult and obscure. The same may be said of Pennhurst's own medical staff when a resident's regularly-assigned physician is absent for whatever reason (vacation, sick leave, etc.), the result is clearly a dangerous situation for any Pennhurst resident whose medical condition is fragile. This problem extends even to the formal annual physical exams which we generally found on most charts: these exams tend to be extremely sketchy and superficial, and generally conclude only with a single diagnosis of "mental retardation", even where powerful drugs such as Tagamet and Dyazide, which have no known use in treating mental retardation per se, are being used. One can only conclude from such documentation that drugs are being prescribed irriationally, or as is more probably the case, that drugs which have or once may have had some relevance to medical problems are being prescribed without continuing evaluation of the client's present needs. (The problem is compounded, incidentally, by use of two different forms for physical

examinations, varying from client to client: one of these forms is really only a "review of systems" which is quite inadequate for such use, not having even space for such essential information as vital signs (blood pressure, pulse, respiratory rate, temperature).

Use of psychotropic medications is particularly problematic. Orders for these drugs are regularly written without a precise statement or description of behaviors which they are intended to control. The result is that staff who provide day-in day-out care have no specific information concerning behavioral observations needed to assist physicians in assessing the effects of these drugs: consequently behavioral observations, when recorded at all, are couched in vague and highly subjective terms. This problem extends even to those clients who are regularly seen by a psychiatrist: this consultant's notes consistently contain recommendations for psychotropic treatment based on sketchy information whose source is not documented. The record of one deceased client, L C , contains an unfortunate example of the kind of therapeutic chaos which can result from this situation. Mr. C 's monthly Team Leader Note for May 1977 complains that the attending physician refused to prescribe psychotropic medication despite the psychiatrist's recommendation to do so, and suggests that this refusal constituted a violation of Mr. C 's human rights. Four months later the Team Leader reported that the Unit Director had appealed to the acting Medical Director for institution of psychotropic drugs. Two months later still, and again three months after that, the psychiatrist noted that Mr. C was receiving no psychotropic medications but behaving acceptably. Finally, in utter confusion over this series of events, the psychiatrist recommended (April 6, 1978) that Mr. C should "continue with current medications", even though he was receiving none, because he was "adjusting well to modular". With documentation such as exists at Pennhurst, the psychiatrist's confusion is hardly surprising.

III. Programming

In the above section of this report we emphasized inappropriate and poorly-informed use of psychotropic drugs at Pennhurst; we did so because such practices are generally symptomatic of inadequate pr lanning and program execution. Developmentally disabled people are often unable to arrange their environment to suit their emotional needs, and resort instead to maladaptive behaviors. Using drugs to suppress these behaviors may serve as a convenient substitute for programs designed to help alleviate disability, but the long-term result is that disability is perpetuated rather than relieved.

Psychotropic medication is overused, and used as a substitute for progra on a large scale at Pennhurst. In Quaker Hall (second floor) twelve records were reviewed. Eleven individuals were on psychoactive drugs, and one of these, R G , was on five psychoactive drugs simultaneously. In no instance of any record examined was there documentation of less restrictive methods of behavior modification being tried, nor did any of the annual Program Reviews reflect any serious attempt to address the issue of replacing psychoactive drugs with more constructive forms of behavior management. Indeed, the annual Reviews are so lacking in medical input (other than routine health-maintenance nursing matters) that we have the impression that Pennhurst physicians are not really looked upon as part of the program team, but rather as detached professionals whose actions are beyond the realm of team discussion.

Finally, we noted that the Pennhurst Infirmary is being used as a "last resort" placement for residents who continue to exhibit unmanageable behaviors despite drugging. In the absence of even a trial of a program of carefully designed behavior management, this practice is clearly highly restrictive and inappropriate.

IV. Health-related environmental issues

One of the most serious problems observed, and noted from the records, which affects not only the mental and physical health of the residents but also their continuing general development and well-being, was their universal and all-pervasive idleness. While ultimately affecting residents' emotional and intellectual development, the most immediate and obvious effects are accident, injury, self-abuse, and abuse by staff. We observed repeated instances of staff abusing residents by shouting across the room to residents and to one another - a form of abuse which while it may be unintentional is one against which many residents have little defense, and little capacity to respond except through self-stimulation and other maladaptive behaviors. The abundance of aberrant behavior is a sign of Pennhurst's emotionally depriving environment.

We observed one lunchtime meal in Capitol Hall I, and saw a number of problems. Many wheelchairs were not properly adapted either for posture or for use at mealtime: some were too high to fit under the tables, requiring their users to reach too far to feed themselves comfortably; in others a built-on tray was so high as to make self-feeding awkward. Unsupervised stealing of food was noted. Non-self-feeding residents were being fed hurriedly, using the dangerous technique of raking food off spoons by drawing them upwards over the upper teeth - an open invitation to choking and aspiration. Rarely could we locate prescriptions for proper amounts of fluid intake, or records of urinary output.

V. Record-keeping practices

We have already mentioned two problems encountered in Pennhurst's record system: lengthy gaps in records, and use of different forms for annual physicals, at least one of which is not suited for that use. Another problem

is the way seizure records are kept. Staff members are instructed to record seizures individually on small slip-like forms which are later taped into the record, often mixed in with laboratory reports and other forms of similar size. While the convenience of this system may help insure that seizures are in fact recorded, we suspect that it may also be detrimental to medical management: instead of being able to see a running summary of seizures written down in a single place, the physician, in order to observe trends in seizure frequency and thus to correllate them with previous modifications of anti-convulsant regimens, must riffle through page after page of slips, abstracting dates along the way. Such a procedure is time consuming, and ultimately must interfere with timely and comprehensive anticonvulsant review. The fact that numerous deaths from seizures have occurred at Pennhurst suggests that this record-keeping practice is not only inconvenient but dangerous as well.

Physician progress notes are extremely difficult to follow because they are kept in different places, using different forms. Infirmary progress notes may or may not be on a form provided for that purpose; residential unit notes are kept on at least two different forms, one of which contains parallel columns for notes and orders, the other being for notes only. Physicians and nurses alike use these forms, and many of the nurses' notes appear to be substitutes for physician notes (for example, the nurse might record that "Dr. Jones examined Mary because of fever. He found such-and-such and prescribed so-and-so". This practice we consider hazardous, and believe that it should be used only in unusual circumstances, such as when the physician is called to another area for an emergency before being able to record his own findings. The net effect of these progress note practices is to fragment the record of the resident's care, making it difficult to audit and difficult to use, particularly for "after hours" physicians who may not have continuing familiarity with the case.

VI. Summary and Conclusions

Medical care at Pennhurst, for a variety of reasons, is inadequate. Viewed in terms of traditional medical care, Pennhurst residents do not receive periodic comprehensive assessment of their condition, their progress, and their long and short term medical needs. This leads, for example, to rote reordering of and exposure to side effects of drugs for which the original need has long since become obscure; inattentive seizure management; failure to evaluate chronic life-threatening conditions which may be highly treatable; and failure to take effective action to eliminate known life-threatening behavior.

In terms of contemporary standards of practice in a residential facility for the retarded, medical services at Pennhurst suffer most on account of almost total lack of participation in an interdisciplinary process of resident program planning, implementation, and review. The single most pervasive effect is that maladaptive behaviors are overwhelmingly dealt with by use of psychotropic drugs, which do nothing to promote development and may actually retard it, rather than by using behavioral and educational programs which if well-designed and carefully implemented can be a powerful adjunct to promoting development. The problem is compounded, however, by the apparent lack of the other services crucial to implementation of the interdisciplinary model, and by a sense of professional distance - even antagonism - between Pennhurst's physicians and its other disciplines.

VII. Recommendations

Many observations are offered in the sections above whose need for corrective action, and the nature of that action, will be readily apparent. Those offered below are intended to complement the foregoing.

1) There must be a careful orientation of the new Medical Director to problems of Pennhurst's medical program.

2) Provide a continuum of "sensitivity" raising medical grand rounds monthly for one year. Then the effectiveness of this, including the need to continue, should be evaluated.

3) Provide a mandatory continuing education program for all physicians, emphasizing the interdisciplinary and developmental models. These programs are offered in many of the so-called University-Affiliated Centers.

4) Physicians' case loads should be no more than 1:0 clients.

5) Use of separate physicians for night coverage should be discontinued. Physician assistants might be employed full time to assist in night coverage as well as for other "physician-extender" functions including interdisciplinary team meetings.

6) Verbal orders by physicians should be minimized. When orders are written, the purpose of the order, expected results, and the more frequent side effects of the drug, if pertinent, should be recorded.

7) Progress notes of all disciplines, including physicians, should be melded, whenever possible, to present a more accurate and meaningful status report of the resident.

8) A critical review of long term medication should be done at least monthly, stating the purpose of the drug, results, and reason for continuing the drug.

9) There should be a monthly review of accidents, injuries, etc. for the purpose of instigating general preventive measures. Some of these might be the addition of programs (particularly behavioral programs), removal of hazards (slippery floors, etc.), better staff coverage at critical periods (getting up in the morning, bathing, feeding, etc.)

10) A clearer definition of use of outside resources such as outside hospitals, consultants, elective surgery, restorative surgery, etc. should be developed by the medical staff.

11) Ward records should be regularly reviewed for continuity, clarity, and pertinence.

12) The service of a nutritionist should be obtained to assist in ordering individualized diets from a standpoint of total calories, protein, fat, carbohydrates, minerals, vitamins, consistency, liquid intake, etc.

13) Staff who feed residents need special training in feeding techniques.

14) Provision should be made for adaptive equipment including, but not limited to, wheelchairs, walkers, crutches, braces, feeding devices, etc.

15) Monitoring of the use of psychotropic drugs should be considered at the meeting scheduled for July 21, 1980.

Respectfully submitted,

James D. Clements, M.D.

John W. Coolidge, M.D.

OFFICE OF THE SPECIAL MASTER
FEDERAL DISTRICT COURT

649 S. HENDERSON ROAD
2ND FLOOR
KING OF PRUSSIA, PA 19406

(215) 265-5401
(800) 362-0352

PILCOP

AUG - 4 1980

July 30, 1980

Hon. Raymond J. Broderick
United States District Court
10613 United States Courthouse
601 Market Street
Philadelphia, PA 19106

Dear Judge Broderick:

Enclosed is an Appendix to the report filed on July 15, 1980, submitted to me by Drs. Clements and Cooledge. The Appendix adds more detail to the analysis of certain deaths at Pennhurst, and comments on unacceptable medical practices at the institution.

I anticipate that this material will be covered in some detail at the hearing on August 4, 1980.

Sincerely,

Carla

Carla S. Morgan
Special Master

Exhibit A

APPENDIX

to

REPORT OF VISIT

PENNHURST CENTER

SPRING CITY, PENNSYLVANIA

June 28 - 29, 1980

James D. Clements, M.D.

John W. Cooledge, M.D.

I

In preparation for our visit to Pennhurst Center, one of us (J.W.C.) undertook a comprehensive review of the summaries (and where applicable, autopsy reports) of deceased residents which were supplied to us prior to our visit. In order to gain a clearer picture of the occurrence of these deaths on a unit-by-unit basis, and according to the primary physician responsible for each resident at the time of death, we attempted to compile these data in a more readily accessible form. In roughly one-third of these cases we were unable to identify the resident's "home" unit from the materials supplied (in these cases the unit of record at death was identified only as the Pennhurst infirmary or as the Phoenixville Hospital, even if only the last few days or hours of life were spent in those facilities): determination of the "home" unit was therefore based on additional information supplied at our request. Likewise, determination of each resident's primary physician at the time of death was based on a series of schedules, supplied by the Office of the Special Master, indicating the physicians assigned to each unit

over varying dates during the period when these deaths occurred. The information thus compiled is exhibited below in Table I, "Pennhurst Deaths by Unit/Subunit, 3/17/78 - 4/30/80," and in Table II, "Pennhurst Deaths Tabulated According to Primary Physician, 3/17/78 - 4/30/80." These tables do not include deaths subsequent to 4/30/80, summaries of which were provided to us subsequent to our arrival for this visit, though a comment about one of these later deaths will be provided further on in this appendix.

Both of the tables below show residents' names, month/year of death, and in parenthesis, age at death. No attempt has been made to analyze these data for the effects of variables such as unit population; physician caseload; residents' ages at death; or length of physicians' employment.

Table I: Pennhurst Deaths by Unit/Subunit

3/17/78 -- 4/30/78

Infirmary I

F	A	8/79	(68)

Eisenhower Unit

Devon Hall 1

N	M	5/78	(16)
B	J	1/80	(18)

Devon Hall 2

S	T	12/78	(37)

Devon Hall 3

S	G	10/79	(16)

Devon Hall 4

H	M	10/78	(35)

Eisenhower Unit, cont.

Penn Hall 1

N	W	6/78	(63)
B	J	8/78	(52)
P	R	11/79	(57)

Penn Hall 2

C	L	11/78	(45)

Humphrey Unit

Horizon 2

D	B	3/80	(45)

Horizon 3 West

T	V	2/79	(52)

Horizon 4 West

S	J	1/79	(42)

Independence Unit

Ind. Dr. 6

L	W	4/78	(62)

Ind. Dr. 9

W	S	12/79	(21)

Ind. Dr. 10

M	J	8/78	(52)

Johnson Unit

Industry Hall

B	D	3/78	(18)

Industry Hall 2

M	A	8/79	(18)

Johnson Unit, cont.

Whitman Hall 2

M	A		2/79	(61)
B	M		1/80	(62)

Lincoln Unit

Capitol Hall 1

S	E		5/78	(64)
S		F	12/78	(67)
C	L		12/78	(43)
S	M		1/79	(72)
L	M		7/79	(64)
D		F	3/80	(33)

Pinehill (off-campus nursing home)

C	L	5/78	
F	V	2/79	
R	P	3/79	
J	C	5/79	
S	R	12/79	
G	T	3/80	
D	A	4/80	

Truman Unit

Mayflower Hall 1

F	M	6/79	(61)
V	B	10/79	(32)

Tinicum Hall 1

B	R	3/79	(55)

Washington Unit

Keystone Hall 5

M	M	10/78	(37)
H	C	11/79	(35)

Keystone Hall 7

M	W	4/79	(37)

Keystone Hall 8

G	F	9/78	(52)

Unit 1

Modular 4

S	E	3/78	(64)

Unit 9

Ward 48

M	P	9/78	(73)

LOA/Trial Visit

G	H	3/78	
E	C	4/80	

Table II: Pennhurst Deaths Tabulated According to Primary Physician

3/17/78 -- 4/30/80

Dr. Ausman

S	E	5/78	(64)
H	M	10/78	(35)
C	L	11/78	(45)
S	T	12/78	(37)

Dr. Ausman, cont.

S	G	10/79	(16)
F	R	11/79	(57)
B	J	1/80	(18)

Dr. Dorrance

S	F	12/78	(67)
C	L	12/78	(43)
S	M	1/79	(72)
L	M	7/79	(64)

Dr. Kearney (no longer employed)

M	P	9/78	(73)
S	J	1/79	(42)
T	V	2/79	(52)

Dr. Ja Kim

D	F	3/80	(33)

Dr. Tai Kim

C	B	3/80	(45)

Dr. Robles

B	D	3/78	(13)
M	A	2/79	(61)
M	A	3/79	(18)
B	M	1/80	(62)

Dr. Shields (no longer employed)

S	E	3/78	(64)
N	W	6/78	(63)
D	J	8/78	(52)
M	J	8/78	(52)

Dr. Wilton

L	W	4/78	(62)
G	F	9/78	(52)
M	M	10/78	(37)
M	W	4/79	(37)
H	C	11/79	(35)

Dr. Woo

N	M	5/78	(16)
B.	R	3/79	(55)
P	W	6/79	(61)
V.	B	10/79	(32)
W	S	12/79	(21)

II

In addition to observations concerning specific residents (both living and deceased) cited in the body of our report, we examined the records of several other residents, and offer the following further observations about them, as well as additional comments about certain clients already mentioned. First, we reiterate our absolutely consistent findings concerning poor documentation of the medical care process, lack of physician participation in the interdisciplinary planning process, sketchiness of annual physical examinations, and general lack of medical diagnoses beyond "mental retardation," even when it was evident that other complicating factors (seizures, motor handicaps, etc.) were present.

1. C. D. (currently living in Modular 3 unit): Mr. D presently receives two major psychotropic medications and has regularly

been seen by the psychiatric consultant since at least 1978. Despite this, no behavioral data have been kept which would document specifically why he is given these drugs, or provide the psychiatrist with an objective basis for recommending continuation or modification of drug therapy. The psychiatrist's progress notes document only the sketchiest impression of clinical progress, based on information from unidentified sources.

2. H_____ H____ (deceased): Problems surrounding management of Mr. H 's seizures, which ultimately resulted in his death, are cited in the body of our report. Of additional interest in his case is another example of the inadequacy of psychotropic drug management which we found at Pennhurst. On 10/11/78 the psychiatrist recommended a change of living unit to see if Mr. H 's behavior would be improved thereby, and then stated that "Later a trial on phenothiazines is indicated if he doesn't respond to environmental changes." As of that date, Mr. H was in fact already receiving a phenothiazine (Mellaril), as he had been for at least the previous twelve months, and was receiving another major tranquilizer (Haldol) as well.

3. C____ H_____ (deceased): Mr. H died while on Trial Visit to a community facility in November 1979, ten months after leaving Pennhurst. His medical management at Pennhurst, and the apparent lack of predischarge planning for followup medical care, appear deficient.

Mr. H was diagnosed in July 1977 as having both anemia and a pyloric ulcer (a lesion of the upper gastrointestinal tract which can cause, among other things, anemia due to intestinal bleeding). This was treated with Tagamet and antacid, and a followup October 1977 X-ray study "failed to show" the ulcer previously demonstrated. Mr. H nevertheless continued to be anemic, despite treatment with iron, and eventually a sigmoidoscopy

(visual examination of the lower intestinal tract) was performed in an effort to explain why his stools still showed evidence of intestinal bleeding. This examination was negative. Mr. H was then discharged to trial visit status on 1/11/79, with a moderately severe and still unexplained anemia and a history of pyloric ulcer, a notoriously recurrent medical problem. He died, age 35, ten months after discharge from Pennhurst: available records do not disclose the cause.

Two problems can be cited in Mr. H 's record. First, persistence of anemia in the presence of a recent positive history of pyloric ulcer should raise the question of persistence or recurrence of the ulcer, and should suggest that additional diagnostic study (repeat X-ray study, or better yet, gastroscopy) is indicated. The record shows no evidence that additional study was considered. Second, Mr. H 's case demonstrates inadequate medical discharge planning: nowhere in the record can there be found, prior to discharge, any evidence that those responsible for implementing his community living arrangements were given particular notice that he had a significant set of medical problems for which special followup was needed. Information about these conditions is contained in the medical Discharge Summary dated 1/11/79, six days after discharge, but even this summary contains no suggestions for followup which could have been acted upon by the community agency.

4. L____ C____ (deceased): The body of our report discusses what we termed the "therapeutic chaos" surrounding disagreement between the consultant psychiatrist and the primary physician concerning Mr. C 's need for psychotropic drugs, and the psychiatrist's subsequent confusion as to whether drugs were in fact being given. The initial source of this chaotic

situation deserves comment for purposes of illuminating further our views concerning the use of psychotropics at Pennhurst.

On 9/15/77 the psychiatrist recorded the following in Mr. C 's chart: "Behavior somewhat unmanageable in that he swaggers around at whim and interferes with ward routine." On this basis, he recommended resumption of the psychotropic drug Haldol, which Mr. C had been receiving earlier.

According to the F.D.A.-approved labelling of Haldol which was then in effect (Physicians' Desk Reference, 1977, pp 1026-1027), "Haldol (haloperidol) is indicated for use in the management of manifestations of psychotic disorders. It is also indicated for the control of tics and vocal utterances of Gilles de la Tourette's syndrome."[1] Neither in the note of 9/15/77 nor in any subsequent thereto did the psychiatrist suggest either that Mr. C had either a psychotic disorder, Gilles de la Tourette's syndrome, nor tics or vocal utterances characteristic of that syndrome. The record indicates that Dr. Shields, the primary physician, considered this recommendation inappropriate and refused (despite considerable pressure from other staff members) to implement it.

The unacceptable behavior described by the psychiatrist on 9/15/77 might in fact have been responsive to Haldol, in the sense that the drug's non-specific central nervous system depressant properties might have supressed to an extent his alertness and desire for physical activity, thus reducing his tendency to "swagger around" and to "interfere with ward routine." We suggest

---

[1] Subsequent additions to the approved indications for Haldol include "combative, explosive hyperexcitability" and certain forms of hyperactivity in children: these indications appear inapplicable to this case.

however, that these arguably inappropriate behaviors are hardly surprising in an ambulatory adult man confined to a closed institution: a response far more appropriate than suppressing such behavior with a CNS-depressant drug would have been to insure that Mr. C had access to a variety of suitable, meaningful activities, and that he was provided a training program designed to teach him to participate in them. Almost certainly such training and activities could have led not only to a decrease in the unacceptable behavior, but to relief of boredom and developmental growth as well.

In short, we would agree with the primary physician that the psychiatrist's advice to resume drugging was inappropriate, and that these behaviors should have been addressed through programmatic, not medical, means. Mr. C 's Annual Program Review showed no meaningful attempt to do so.

5. G S (deceased): Ms. S was admitted to the Pennhurst infirmary on 10/3/79, suffering from fever and lethargy following a series of seizures, a constellation of problems with which she had often had difficulty in the past. But despite the fact that she was receiving three anticonvulsant drugs which had just failed to prevent a series of convulsions, anticonvulsant blood levels were not obtained either then or prior to her death six days later.

On the following day, 10/4/79, Ms. S was thought to have tonsillitis (the chart also reveals physical findings compatible with pneumonia), and an antibiotic was prescribed. Her condition appeared to stabilize somewhat over the next few days, but on 10/9 she again showed fever and was switched to another antibiotic: at that time the physician also wrote an order, "Force fluids," apparently because of poor oral intake. That evening, the

Nurses' notes contain the following incredible entry: "Listless--unresponsive [---] fluids forced." Shortly thereafter, at 9:05 p.m., she was found dead.

Aside from the incredible danger of aspiration and suffocation occasioned by "forcing fluids" into a person who is "listless--unresponsive" (the thought of pouring fluids into the mouth of an essentially unconscious person is enough to make one cringe), the features of Ms. S 's case (on paper, at least) are strongly reminiscent of a syndrome which we have repeatedly observed at other facilities, and which (judging from the records) may have been present in several other deceased Pennhurst residents as well. The syndrome is characterized by the presence of (1) a seizure disorder being treated with one or more anticonvulsant drugs; (2) significant motor handicaps, usually to the point that the person is nonambulatory and must be fed by others; (3) chronically marginal nutritional status, or outright malnutrition; (4) cyclic episodes of slowly progressive lethargy (which is usually noticed by staff) and dehydration (which usually is not) due to insidious further failure of oral intake, which leads in turn to (5) progressive concentration of anticonvulsant drugs in the bloodstream to toxic levels. If medical and nursing staff personnel do not keep this syndrome in mind at all times when dealing with such clients, its diagnosis is easily missed, for two reasons: first, standard laboratory tests commonly relied upon to assist in diagnosing dehydration (blood electrolytes, blood urea nitrogen and creatinine) tend to remain within normal limits; and second, changes in skin texture usually associated with dehydration tend to be either very subtle, or to be confused with lack of subcutaneous fat associated with being chronically underweight. The most direct and immediately effective treatment for this syndrome, in our experience, has been institution of

nasogastric tube feeding, by which it is possible not only to effect rapid reversal of the failure of oral intake, but also to avoid the hazard of "forcing fluids" into the mouth of an unresponsive patient.

Our purpose in offering a rather technical description of this syndrome and its treatment is not so much to edify the Special Master as to alert the Pennhurst medical staff, on the assumption that this report will be shared with them.

6. W W (deceased): Mr. W expired on 6/18/80; he thus is not included in the tables in section I of this appendix.

Like J S (cited in the body of this report), Mr. W died of suffocation after aspirating a foreign body--in this case, a paper towel, which he apparently obtained from a bathroom dispenser during a middle-of-the-night stroll around his living unit. Though we did not review his complete record, we did note on the "Facility's Report of Unusual Incident," signed by the Superintendent, that "Mr. W has a history of getting out of bed during the night and roaming around the area." During our visit, we were told, but did not record the source of the information, that Mr. W also had a recurrent history of ingesting paper towels. Though we recognize the hearsay nature of this latter information, we suggest that the Special Master may wish to look further into whether recurrent ingestion of foreign bodies is widespread at Pennhurst, particularly since Mr. S 's and Mr. W 's deaths occurred from essentially identical preventable causes.

Respectfully submitted,

James D. Clements, M.D.

John W. Cooledge, M.D.

JDC:JWC:bw

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

TERRI LEE HALDERMAN et al.,	:	CIVIL ACTION
Plaintiffs	:	
v.	:	
PENNHURST STATE SCHOOL AND HOSPITAL et al.,	:	
Defendants	:	
UNITED STATES OF AMERICA,	:	
Plaintiff-Intervenor	:	FILED JUL 23 1980
PENNSYLVANIA ASSOCIATION FOR RETARDED CITIZENS et al.,	:	
Plaintiffs-Intervenors	:	NO. 74-1345

ORDER

AND NOW, this 22nd day of July, 1980, plaintiffs having on March 6, 1980 filed a motion for contempt in connection with the deaths of Pennhurst residents and having on March 11, 1980 moved for a temporary restraining order in connection with the deaths of Pennhurst residents, which motion was resolved by an agreement of the parties dated March 13, 1980, which agreement provided in part "The Special Master, with the assistance of any consultants retained for that purpose, shall investigate the deaths and report to the Court," which report, prepared by James D. Clements, M.D. and John W. Cooledge, M.D., was submitted by the Special Master and filed with the Court on July 15, 1980, which report states, in part: "Records of deceased and living clients shared certain characteristics. We found gaps, sometimes of several months; in decedents' charts these gaps were often just prior to the terminal event;" ". . . documentation of the process of medical diagnosis and treatment is scandalously poor;" "Use of psychotropic medication is particularly problematic;" "Psychotropic medication is over-used, and used as a substitute for program on a large scale at Pennhurst;" "The abundance of aberrant

ENTERED: 7/23/80

CLERK OF COURT

Exhibit B

behaviors is a sign of Pennhurst's emotionally depriving environment;" and "Medical care at Pennhurst, for a variety of reasons, is inadequate;" the Court hereby ORDERS that defendants Jennifer Howse and George Kopchick and Acting Pennhurst Medical Director William Dorrance, appear on Monday, August 4, 1980 at 10:00 a.m. in Courtroom 10B of this United States Courthouse, 601 Market Street, Philadelphia, Pennsylvania to SHOW CAUSE why they should not be held in civil contempt for violation of the following provisions of Orders of this Court: paragraphs 12, 14 and 15 of the Order of March 17, 1978, as amended April 24, 1980 and paragraphs 3.4, 3.5, and 3.7 of the Order of March 5, 1979, as amended April 24, 1980.

It is FURTHER ORDERED that said defendants SHOW CAUSE why the recommendations made by Drs. Clements and Cooledge which are not already contained in Orders of this Court should not be adopted as Orders of this Court.

It is FURTHER ORDERED that plaintiffs serve true and correct copies of this Order on the defendants Jennifer Howse and George Kopchick and Acting Pennhurst Medical Director William Dorrance.

RAYMOND J. BRODERICK, J.

TABLE I

CURRENT STATUS OF FORMER PENNHURST RESIDENTS

(N=142)

Status	Number	Percent
Persons in Community Programs *	122	85.9%
Persons Returned to Natural Family	9	6.4%
Transferred:		
Pine Hill (ICF-MR)	5	3.5%
Other Institutions	3	2.1%
Deceased	2	1.4%
Community Program Out of State	1	.7%
TOTALS	142	100.0%

NOTE: None of the 142 persons has been readmitted to Pennhurst.

* Of the 122 persons in community living arrangements:

102 are in programs for 3 or fewer persons
18 are in programs for 4 to 6 persons
2 are in programs for 7 to 8 persons

A-30 Exhibit C

TABLE VII

HEARING *

	Relocated to CLA's (a)		Remaining at Pennhurst (b)	
	Number	Percent	Number	Percent
No difficulty in hearing	106	86.9%	873	89.8%
Some difficulty in hearing	9	7.4%	59	6.1%
Great difficulty in hearing	5	4.1%	22	2.1%
No hearing at all	2	1.6%	18	2.0%
TOTALS	122	100.0%	972	100.0%

VISION *

	Relocated to CLA's (a)		Remaining at Pennhurst (b)	
	Number	Percent	Number	Percent
No difficulty in seeing	88	72.1%	710	73.0%
Some difficulty in seeing	25	20.5%	134	13.8%
Great difficulty in seeing	7	5.7%	65	6.7%
No vision at all	2	1.7%	63	6.5%
TOTALS	122	100.0%	972	100.0%

* Data taken from Pennhurst records

(a) N=122

(b) N=972

EXHIBIT D

A - 31

TABLE VIII

AMBULATION *

	Relocated to CLA's (a)		Remaining at Pennhurst (b)	
	Number	Percent	Number	Percent
Walks with no difficulty	84	68.9%	612	63.0%
Limps or walks unsteadily	21	17.2%	194	19.9%
Walks only with help	5	4.1%	55	5.7%
Unable to walk	12	9.8%	111	11.4%
TOTALS	122	100.0%	972	100.0%

DISTRIBUTION BY SEX *

	Relocated to CLA's (a)		Remaining at Pennhurst (b)	
	Number	Percent	Number	Percent
Male	81	66.0%	608	62.6%
Female	41	34.0%	364	37.4%
TOTALS	122	100.0%	972	100.0%

* Data taken from Pennhurst records

(a) N=122

(b) N=972

EXHIBIT E

TABLE X

INDIVIDUALS' VISITS WITH FAMILY IN THE COMMUNITY AND AT PENNHURST

N=106 (1)

	In CLA (a)		At Pennhurst (b)*	
	Number	Percent	Number	Percent
Family visits individual at least monthly	45 (2)	42.5 %	15	14.2 %
Individual visits or takes trip with family at least monthly	36	40.0 %	4	3.4 %

* Data taken from Pennhurst Records.

(a) For the six months after moving to community.

(b) Same individuals for the two years prior to moving to community.

1. 16 individuals of the 122 who moved to the community have no known family.

2. At least 49 individuals have regular contact with other individuals who are not family members.

A-33 EXHIBIT F

TABLE XI

FAMILY PARTICIPATION IN SERVICE PLANNING PROCESS

(N=122)

Level of Participation	Participation in IHP*		Participation in APR**	
	Number	Percent	Number	Percent
All	40	32.8%	3	2.5%
Some	35	28.7%	12	9.8%
None	31	25.4%	89	73.0%
Family Unknown	16	13.1%	16	13.1%
Missing Data	---	----	2	1.6%
TOTALS	122	100.0%	122	100.0%

*Participation in Individual Habilitation Plan (IHP) Process:

All = participated in meetings, reviewed and approved all plans.

Some = participated in meetings, and/or reviewed and approved some plans.

None = no participation

**Participation in Annual Program Review (APR) Process:

Data taken from Pennhurst records for the two years prior to individual's movement to the community.

The Annual Program Review is the mechanism utilized at Pennhurst to design a person's program; family members are invited to participate.

AFFIDAVIT OF ABRAHAM ZLOTNIKOFF

1. I am Abraham Zlotnikoff. I am seventy six years old.

2. I work every weekday at the Elwyn workshop. On Saturday and Sunday I have it easy. At the workshop I do forks, put rubber bands on, do different colored spoons - - white ones and all. I'd like to get a job helping out in the kitchen. I could do that. At Pennhurst I used to work in the kitchen. I dried dishes, dried the pots. Here Marc is teaching me how to cook hamburgers.

3. Today I went bowling, we go to different places. At the school I get coffee. I went for coffee the other night. They show movies at the school in town. They have a screen. We take the train to get to town.

4. I like baseball, basketball, football, and fights. I went around the corner to see a baseball game. Kevin took me to see the game. There's a coke machine at work.

5. I like it better here than at Pennhurst. I help to clean the house up here. They keep their eye on you up at Pennhurst. I've had enough of it -- in the old days -- no more. My brother knows that. I have a room here by myself and I have my own TV.

6. Downstairs we have have a washer and a dryer. I put my clothes in there myself. At Pennhurst they're in charge of that. Here I do my own.

7. I was a resident of Pennhurst for about seventy years. For about the last six months, I have lived at a community placement run by the Unived Cerebal Palsy Association. I live in a house at 49th Street and Parkside, in Philadelphia, with three other residents plus staff.

A35 Exhibit H

I, Abraham Zlotnikoff, hereby declare, under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge, information and belief.

Date November [illegible]

[signature] 11/11/11

Witnessed

Marc Pomerantz

Hannah M Shanklin

AFFIDAVIT OF MRS. ANTHONY NASIELSKI

1. My name is Mrs. Anthony Nasielski. I am the mother of Paul Nasielski.

2. Paul is sixteen years old. He lived at Pennhurst for about six years. Before that he was at a private school in Delaware for three years. We placed Paul in the Delaware school because at that time there was nothing except Pennhurst for a severely retarded, emotionally disturbed child such as Paul. We also have another handicapped child, who Paul was upsetting. Paul became too difficult for the school in Delaware and we had to place him in Pennhurst. The last place we ever wanted to see Paul was Pennhurst. When we were faced with the reality that he would have to go there, that was very difficult for my husband and myself.

3. As Paul stayed in Pennhurst longer and longer, he seemed to get more and more difficult. It was the wrong kind of environment for him. There was too much distraction and too many people. It was completely the opposite of what he needed.

4. Since this spring, Paul has been living in a community placement in Ardsley, Pennsylvania. It is just marvelous. He receives a lot of tender loving care, and the people who work with him are just wonderful. He has calmed down a lot, although I know he has a long way to go. Last week he had a birthday party, and it was beautiful to see. It has been years since I have seen him like that. He was smiling and very happy.

5. Paul's last year in Pennhurst was especially bad. Apparently he was becoming more aware of things. When we came to visit and had him in the car, he would never want to go back. He would scream and holler and we had to drag him out of the car. It was so painful. Now when we go and visit Paul, he is happy to see us, but he is also obviously happy to be there. For the first time in years I feel I have some peace of mind.

6. I was at first opposed to Paul's moving into the community. I work in the Mental Health Center in Norristown and in Norristown we

 Exhibit I

have the results of all the people being dumped into the community: living in dirty boarding homes, fed inadequately, no proper clothing. All I could imagine was what would happen to Paul. I couldn't conceive of him living in a group home because he needs extensive, individual care.

6. At first I told Paul's caseworker that I would not have anything to do with Paul's moving from Pennhurst, because I didn't think he was going to get that individual extensive care. I told his caseworker that only if Paul received one-on-one staff attention would I consider his transfer. She said that was what he would have. I didn't believe it because there has been nothing like this in the past, but I am open-minded. I agreed to go look at some group homes.

7. One day last summer Paul's caseworker took me around to look at the group homes. I met Mr. Lynch, who runs the homes. In one home, there was a boy much like Paul. He lived in a lovely house with his own bedroom. I saw him rocking in his rocking chair. He had been living there over a year, and there were two staff people at all times. I just sat down and cried, I couldn't believe it.Another boy from Pennhurst had just moved in that day, and they told me this is what Paul could have too.

8. I had many things that I wanted for Paul, many demands and I got them. Paul has trouble sleeping, and I wanted there to be someone there with him. The staff is in shifts, and there is always someone awake there. I asked for door locks, and I got them, although they don't need to keep the doors locked twenty-four hours a day because Paul is watched and he doesn't run out.

9. In my opinion, Paul would definitely not have left Pennhurst without the court order.

Mrs. Joan Nasielski
212 West 4th Ave.
Conshohocken, Pa. 19428

I [illegible] hereby declare, under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge, information and belief.

[illegible]

A39

AFFIDAVIT OF PATRICIA DOUGHERTY

1. My name is Patricia Dougherty. I am the sister of Robert Gorman.

2. Robert is twenty two years old. He was a resident of Pennhurst for approximately eight years. Before that he had spent time in St. Edmunds, a Catholic school, and then a state institution upstate.

3. Robbie has been in a community placement in Collegeville since October 1st of this year. It's only been a month, but so far, from what he tells me, he likes it there. It's a beautiful home and he is enjoying it. He goes to a day workshop and so gets out. At Pennhurst Robbie told me he would just sit and watch TV and fall asleep.

4. I wasn't sure at first about the move, but I talked to caseworkers from Delaware County and Montgomery County. Robbie was put with a friend with the same handicap and so was placed in a home in Montgomery County (rather than Delaware County). Everything in the planning for the move was thought out and looked into -- it wasn't just rushed into.

5. I doubt if Robbie would have left Pennhurst without the court order. He probably would have stayed at Pennhurst.

140 Exhibit J

I, Patricia Daugherty, hereby declare, under penalty of perjury, that the foregoing statements are true and correct to the best of my knowledge, information and beliefs

Patricia Daugherty
11/21/20

A41

AFFIDAVIT OF LEONARD SINGER

1. I am Leonard Singer. I am the father of Lawrence Singer.

2. Larry is now seventeen years old. He has been at Pennhurst for about seven years. He went there because he is retarded, and at that time there was no other place but Pennhurst for him.

3. We're hoping for an alternative to Pennhurst. I want Larry to hae something slse. I want him to be comfortable and placed out of danger. He needs one-on-one or one-on-two care and he is not getting that at Pennhurst. Larry can't protect himself and he has been hurt at Pennhurst. I'm very concerned about his safety.

4. We have been working with the Office of the Special Master and the state to come up with some alternative. We've already rejected one alternative because we felt it didn't meet Larry's needs, but we have another alternative and we are waiting for an opening. We will be looking at it very closely to make sure it is best for him. There are many things Larry will never have in life, but he could be more comfortable and placed out of danger. I feel he would have a much more stable existence in the community, and he might be safer. Pennhurst is not the answer.

A42 Exhibit K

I, Leonard Singer, hereby declare, under penality of perjury, that the foregoing statements are true and correct to the best of my knowledge, information and belief.

Date 11/10/80

Leo Singer

AFFIDAVIT OF MARIAN CARANFA

1. My name is Marian Caranfa. I am the mother of George Sorotos Caranfa, one of the original named plaintiffs in Halderman v. Pennhurst. As the District Court found, George was bruised and injured weekly during his seven years, as of 1977, at Pennhurst. Each visit, I found bite marks, scratches, burns, and rashes on him.

2. It is now six years since we filed this lawsuit. Finally, George has benefited. The state and the county created an acceptable community residence and day program and, on August 14, 1980, during a simple, uncomplicated five-minute hearing, the placement was approved by the Hearing Master. This informal hearing was no imposition whatsoever.

3. I did not find the planning process difficult or burdensome. I met with the provider and with others involved in the planning, and we talked it over. We had a big meeting with the Special Master's office, which I really didn't think was necessary because they could have just called me and I would have told them that I approved George's move. I have continued to participate in the planning. On the whole this has gone well, although I feel that the staff from the CLA -- who work with George and best know his day-to-day progress and needs -- should have more of a say. It seems that the County is more in control than the provider.

4. George made the transition from Pennhurst to his new home well. At first, George just went on a couple of short, one hour visits from Pennhurst. I drove him and took him back. Then the visits got longer. The staff from the CLA came and got him a few times. We wanted him to know that he would be seeing both me and them. Then George went on an overnight visit.

A44 Exibit L

5. George has made much progress since his move in August. Since then, he has learned four words: "Anna" (his teacher's name), "goodbye," "eat," and "hi." This is the most he has ever spoken in his life. Before this he would only say, "mum." He is also now learning sign language. George will be eighteen next week and yesterday, for the first time ever, he signalled to me that he had to make a bowel movement. I was so over joyed that I cried. He also will hug and kiss me when I ask him to.

6. George has been very difficult to take places -- he doesn't like crowds, he would throw fits. This past week I took him out to the store and bought him a coat. He still didn't want to stay there for a long time, but we were able to go in and get what we needed. This was a big improvement. George is much better off and happier where he is now, than in Pennhurst.

7. George is doing 100% better in his new home. I no longer find any of the bruises, scratches, bite marks or burns on him that he constantly suffered while at Pennhurst. I feel that this, and his progress in communication, is due to the fact that he receives so much more attention in the community placement than he did at Pennhurst.

I, Marian Caranfa, hereby declare, under penalty of perjury, that the foregoing statements are true and correct to the best of my knowledge, information and belief.

Marian Caranfa

Date Nov 11, 1980

I, William Caranfa agree with the above
Nov 11, 1980

AFFIDAVIT OF JOSEPH MICHAEL SOWICZ

1. I am Joseph Michael Sowicz. I am twenty two years old.

2. I lived at Pennhurst about eight years. I've been living at 1918 South 17th Street, in Philadelphia, since August 4th. The residence is run by the United Cerebal Palsy Association. There are three men in my apartment, and two women in the apartment upstairs. There is one staff person who sleeps on the 3rd floor, at night, and one awake staff person at night. During the morning and evening hours there are two staff people here. I'm going to physical therapy two times a week during the day at Moss Rehab. I'm waiting for the day program to be approved.

3. I like living here and meeting new people. Living here you get out more places. We will be going to movies. Once a month I go to a social club called the RAYS.

4. I wanted to leave Pennhurst because I got the feeling they didn't treat you right. Up there, some of the people were rotten -- they didn't let people come up and go as they wanted -- or visitors come.

5. I'm happier to be here.

(Original signed affidavit on following page.)

A 47 Exhibit M

1. I. am Joseph Michael Sowicz. I am 22 years old.

2. I lived at Pennhurst about 8 years. I've been living at 1918 S. 17th St, in Philadelphia since August 4th. The residence is run by the United Cerebral Palsy Association. There are 3 men in my apartment, and 2 women in the apartment upstairs. There is one staff person who sleeps on the 3rd floor, at night, and one awake staff person during the morning and evening hours there are 2 staff people here.

12/2

I'm going to be physical therapy 2x a week during the day, at Moss Rehab. I'm waiting for the day program to be approved

3. I like living here and meeting new people living here from

will be
~~I'd~~
get out more places we're going to move. Once a month I go to a social club called the ~~Clays~~: RAYS.

4. I wanted to leave Pontchartrain because I ~~electric~~ got the feeling they didn't treat you right. Up there. Some of the people were rotten - they didn't put people come up and go on they wanted on visitors comes

5. Isn't happen to be true

I, Joseph Michael Scurto hereby declare, under penalty of perjury, that the ~~foregoing~~ foregoing statements are true and correct to the best of my knowledge, information and belief

11/10/80 [illegible]
witness

A-49

AFFIDAVIT OF TINA SOWICZ

1. My name is Tina Sowicz. I am the sister of Joe Sowicz. He has no other family.

2. Joe is now in a community placement run by the United Cerebal Palsy Association. He is on an extended pre-placement visit from Pennhurst.

3. I believe that Joey should make his own decisions, and I will go along with whatever he decides so long as it is not obviously detrimental or dangerous to him. I told this to the Hearing Master; if Joey wanted to leave Pennhurst, I would go along with that, and that was his decision.

4. I am not sure that the community is better than Pennhurst for everyone. I think that there should be case-by-case, person-by-person determinations of what services are best for each person. There may be some people for whom Pennhurst is better. It should be decided individually.

5. I am not 100% sure that the community is best for Joey. But he will never know if he doesn't try -- I think it should be given a try.

I Tina Sowicz, hereby declare, under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge, information and belief.

Tina Sowicz

A-50 Exhibit N